DBHDS
Virginia Department of Behavioral Health and Developmental Services

Applications will not be accepted with postmarks dated before September 3, 2013

Individual and Family Support Program Application FY 2014

Name of individual on the waitlist_____

☐ I am an **individual** with intellectual/developmental disabilities who is on a ***waiting list*** for services under the
○ DD Waiver ○ ID Waiver

☐ I am a **family member** of a child or individual with an intellectual/developmental disabilities who is on a ***waiting list*** for services under the
○ DD Waiver ○ ID Waiver

"Family Member" means an immediate family member of an individual receiving services or the principal caregiver of that individual. A principal caregiver is a person who acts in the place of an immediate family member, including other relatives and foster care providers, but does not have a proprietary interest in the care of the individual receiving services. [Virginia Code § 37.2-100]

If you are a family member, does the individual live with you on a permanent basis?
☐ Yes ☐ No If no, please give details:

If you listed yourself above as a family member what is your relationship to the individual for which you are applying:
☐Mother ☐Step-mother ☐Wife ☐Grandmother ☐Sister ☐Father ☐Stepfather ☐Husband ☐ Grandfather ☐Brother ☐Principal Caregiver
☐ Other _____
Will you need an interpreter to assist you with your application? ☐ No ☐ Yes If yes, what language: _____

How did you hear about the Individual and Family Support Program?
☐ Case Manager/Support Coordinator ☐ Consumer Directed Services Facilitator ☐Center for Independent Living ☐ List serve

Individual and Family Support Program, DBHDS, Room 939, 1220 Bank Street, Richmond, VA 23219
If you need an application in another language please call 804-225-3810 for assistance.

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☐ Parent/Advocacy Group (_____) ☐ Website (_____)

Do you know the name of your ID or DD Case Manager? ☐ Yes ☐No
If no, would you like us to find his/her contact information for you? ☐Yes ☐No

ABOUT YOU -the individual on waiting list

Name _____

Address _____
Street City Zip Code County
Telephone Number(s) (h) (w) (c) _____

Date of Birth / / ☐Male ☐ Female

Please tell us a little bit more about some of the funding or assistance you, as a person on the waiting list, may be receiving:
☐ Private Insurance ☐ TRICARE military insurance ☐ Medicaid ☐ EPSDT ☐ DSS ☐ DARS ☐Center for Independent Living

☐ Comprehensive Services funding (FAPT) ☐ Early Intervention services (Part C) ☐ Special Education services (Part B)

☐ EDCD Waiver ☐ Day Support Waiver ☐ Tech Waiver

☐ Other _____

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YOUR FUNDING REQUEST- Name of individual on the waitlist_____

We need to know what help you would like us to consider (please see the *Individual and Family Support Program Guidelines on the DBHDS website for allowable services/items)*, who will benefit, and how it relates to the needs or well-being of you, your child/individual, and/or your family, **in particular how will the service/item support the continued residence of the individual in his own or the family home**. Please provide specific information to show how the amount requested was determined.

I/We need…	**How this will assist me to stay in my home or my family's home:**	**Requested funding amount and frequency of payment:**
Example: We need respite so that we can continue to provide quality care for our adult son in our home.	Example : Respite will give my mom and dad a break from caring for me and give me a break from mom and dad. It will also let me go see my friends on the weekends.	Example : Every other weekend, each weekend is $300, at the ABC respite program , 10 weekends

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TOTAL amount requested _____

***IF you are applying for respite services to cover multiple months up to 1 year, payment will be pro-rated and mailed in equal amounts on a monthly basis regardless of vendor payment or direct payment to the individual.**

Please provide documentation below or with the application showing that all other public funding options have been exhausted.
For example: Medicaid Durable Medical Equipment, EPSDT, EDCD Waiver, Day Support Waiver, Early Intervention (Part C), Public School Systems (Part B).

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Name of individual on the waitlist_____

VENDOR PAYMENT OPTION

Applicants for funding through the IFSP may be receiving other federal, state or local benefits and services. Because financial eligibility for programs varies greatly, funding paid directly to the individual or to a representative on the individual's behalf may be counted as "unearned income" and could impact program eligibility. In order to ensure that recipients of the IFSP do not jeopardize other benefits or services they may be receiving, it may be necessary for supports or services to be paid directly to the vendor providing IFPS supports or services. Money distributed as a vendor payment will not be considered income since the payment goes to the vendor.

IF YOU ARE RECEIVING MEDICAID AND NEED YOUR PAYMENT TO GO DIRECTY TO A VENDOR TO ENSURE FUNDING FROM THE IFSP WILL NOT AFFECT YOUR MONTHLY INCOME ALLOWANCE, PLEASE FILL IN THE INFORMATION BELOW:

Vendor Name _____

Vendor Address _____

Vendor City _____ **State** _____ **Zip CODE** _____

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Employer Identification Number (EIN #) OR Social Security # if an individual (REQUIRED) _____

Exact Amount to be mailed to VENDOR (REQUIRED)_____

IF VENDOR INFORMATION IS NOT FILLED OUT, MONIES WILL BE SENT TO THE ADDRESS on PAGE 2 and made out to the name that is fiscally responsible on page.

Individual and Family Support Program Agreement

Name of Applicant (the individual or family member who will be responsible for IFSP funds and funds mailed to if approved):

_____ Social Security Number _____-_____-_____.
(This will not be reported to the IRS, this is for Homeland Security Act requirements only)(required field)

Name of the person on the waitlist supported by IFSP funds: _____
Last 4 digits of SS# _____ Used for internal tracking of applications only.

This is an agreement between the Applicant and DBHDS. The Applicant is eligible only if the individual with an intellectual or developmental disability is residing in his own home or the family home and is on the statewide waiting list for the Intellectual Disability Medicaid Waiver or the Individual and Family Developmental Disabilities Services Medicaid Waiver.

The Applicant agrees as follows:

- The Applicant acknowledges that the IFSP funds are provided only to the extent that such services are not available or cannot be funded through other public funding sources (including IDEA Part C - early intervention, IDEA Part B - public school services, Medicaid, Medicare, and EPSDT).

- The Applicant acknowledges that all money received through IFSP will be used solely for the purpose(s) documented on the Applicant's IFSP Application.
- The Applicant acknowledges that he/she must present receipts or other documentation to verify that IFSP funds were used to purchase only approved services or items ***within 30 days of receipt of funds*** and shall include the name of the provider of the goods/services and the individual's name. Any misrepresentations of the use of IFSP funds or attempts to misappropriate these funds are strictly prohibited and subject to legal action. The Applicant acknowledges that failure to provide documentation that IFSP funds are used to purchase only approved services or items may result in recovery of such funds and denial of subsequent funding requests.

Name of Person on waitlist: _____

- The Applicant acknowledges that any unspent funds shall be returned to DBHDS for reallocation to other applicants as soon as it is determined that all of the funds are not needed.
- The Applicant acknowledges that any misrepresentation of the individual's/family's needs, and misappropriation of funds will result in immediate discontinuation of funding, and the Applicant will be responsible to pay back any funds received based on such misrepresentation(s) or misappropriation(s). The individual may also no longer have access to IFSP funds in the future.
- The Applicant agrees to permit DBHDS representatives to conduct utilization reviews, including home visits, and shall cooperate fully with such reviews and provide all information requested by DBHDS.
- The Applicant acknowledges that IFSP funding is neither an entitlement nor a grant, and is provided to assist the individual to live at home with his/her family or independently in the community while waiting for waiver services.

☐ I have read, understood and agree to the terms and conditions of the Individual and Family Support Program and that all information provided is true and accurate to the best of my knowledge.

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Fiscally Responsible Person's Name Signature Date

How to apply:
Apply online at www.DBHDS.virginia.gov/ODS-default.htm link will become available September 3, 2014.
OR
Mail in an application to: Individual and Family Support Program, DBHDS, Room 939, 1220 Bank Street, Richmond, VA 23219. If you need assistance with the application, you may call Monday through Friday 9am-5pm 804-225-3810, 804-225-2233 or 804-371-4202.

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